TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Texas Health of Allen

**Respondent Name**
Indemnity Insurance Co of North

**MFDR Tracking Number**
M4-17-2446-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
April 12, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Per Rule 134.403 section E all HCPC's that are paid per the fee schedule should pay per the APC allowable at 200% regardless of the billed charges, we also have attached this rule."

**Amount in Dispute:** $257.35

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Respondent stands by the original payment for the service in dispute. Requestor was reimbursed pursuant to the Medicare fee guidelines for each services billed. Therefore, no additional monies are owed for the date of service 4/14/16."

**Response Submitted by:** Downs Stanford, PC 2001 Bryan Street, Suite 4000, Dallas, Texas 75201

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 14, 2016 | 12002, 90471 | $257.35 | $36.50 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines emergency
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – Payment adjusted because the benefit for this service is included in the payment allowance/for another service/procedure that has already been adjudicated

- 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
- 57 – Unrelated E/M service performed during postoperative period
- W3 – Additional payment made on appeal/reconsideration
- 193 – Original payment decision is being maintained. This claim was processed properly the first time

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule that determines reimbursement?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking $257.35 for outpatient hospital services provided on April 14, 2016. The carrier denied the service in dispute CPT 12002 – "Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm" as 243 – "The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed and 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   28 Texas Administrative Code §134.403 (d) states,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

   Review of the applicable Medicare payment policy found at, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS and the term "**Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1" finds;

   - Procedure code 29125 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed.

     As procedure code 96372 has a status indicator of "S" and 99282 has a status indicator of "V" the carrier's denial of 97 - Payment adjusted because the benefit for this service is included in the payment allowance/for another service/procedure that has already been adjudicated is supported. No additional payment is recommended.

   The other code in dispute 90471 – "Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)" had a payment of $46.75 made by the carrier on June 3, 2016. This service will be reviewed per the applicable fee guideline discussed below.

2. The applicable sections of 28 Texas Administrative Code §134.403 (f) states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Based on the above the maximum allowable for the services in dispute is calculated below:

| Procedure Code | Status Indicator | APC | Payment Rate | 60% labor related | 2016 Wage Index Adjustment for provider 0.9731 | 40% non-labor related | Payment | Maximum allowable reimbursement |
|---|---|---|---|---|---|---|---|---|
| 12002 | Q1 | 5051 | n/a | | | | | |
| 90471 | S | 5692 | $42.31 | $42.31 x 60% = $25.39 | $25.39 x 0.9731 = $24.71 | $42.31 x 40% = $16.92 | $24.71 + $16.92 = $41.63 | $41.63 x 200% = $83.26 |
| | | | | | | | Total | $83.26 |

3. The total allowable reimbursement for the code 90471 is $83.26. The carrier paid $46.75. The requestor is seeking $36.50. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $36.50.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $36.50, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | May 10, 2017<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.